Highmark's Weekly Capitol Hill Report



Issues for the week ending November 13, 2026

Federal Issues

Legislative

Congressional Leadership Elections Underway

Last week, House and Senate Republicans selected their leadership, with the Senate largely unchanged and the House ushering in new leadership. Rep. Jim Jordan's (R-OH) election as House Minority Leader signals a shift in House Republican leadership, he brings extensive committee and conservative leadership experience as the party prepares for two years of oversight and investigations and the 2028 presidential cycle.

House Democrats are expected to hold leadership elections this week with Hakeem Jeffries (D-NY) likely to be elected as the next Speaker of the House. Senate leadership races remain unsettled, with Senator Chris Van Hollen (D-MD) announcing a challenge to Minority Leader Chuck Schumer (D-NY).

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Senate Democrats Probe Insurers' Prior Authorization Commitments

On November 13, letters were sent to major health insurers by Senate Finance Committee Ranking Member Ron Wyden (D-OR) and Senators Jon Ossoff (D-GA) and Sheldon Whitehouse (D-RI) seeking greater transparency into plans' implementation of the June 2025 industry commitments to reform prior authorization. In their letter, the senators argue that aggregate reductions reported do not provide enough detail to assess the impact on patients and providers.

They request data on services removed from prior authorization, approval and denial rates, appeals and reversals, partial approvals, implementation timelines, administrative savings and actual or projected impacts on utilization and premiums, with data broken out for Medicare Advantage, Medicaid managed care and commercial coverage.

The inquiry follows broader scrutiny from Senators Whitehouse and Ossoff. Whitehouse leads S. 4384, the Medicare Advantage Improvement Act, bipartisan legislation to require prior authorization decisions to be made within 72 hours, and expedited decisions within 24 hours, implement real-time approvals for routine, low-risk services integrated with electronic health records, and increase transparency and reporting on plans use of prior authorization. Senator Ossoff released a report in August arguing that prior authorization delays and denials have harmed Georgia patients and can override physician treatment decisions.

Federal Issues
Regulatory

Regulatory Updates

- **Exchange PEV Proposed Rule:** CMS released its Exchange Pre-Eligibility Verification proposed rule on October 23. The proposed rule implements Exchange eligibility and verification regulations required by provisions in the Working Families Tax Cut (WFTC) and aligns with the Treasury Department and IRS proposed rule on the Premium Tax Credit (PTC). AHIP and BCBSA are working with member plans to develop comments in response to both proposed rules, which are due in late November.

- **PBM Final Rule:** The Department of Labor finalized a PBM transparency rule requiring disclosure of direct and indirect compensation to large self-insured employer plans, adding new reporting, auditing and compliance obligations for PBMs and their plan partners.

- **Medicaid Community Engagement:** A federal court struck down part of CMS's Medicaid community engagement rule related to the definition of medical frailty, while upholding other key provisions, including the 12-month lookback period and limits on self-attestations. The ruling gives plaintiffs six months to update their processes for determining medical frailty, and either side has 60 days to appeal.

- **CPT Codes for Maternity Care:** HHS issued guidance allowing HIPAA covered entities to keep using the legacy CPT 2026 Maternity Care Services codes for Maternal Care Service episodes of care in which services begin in 2026 and end in 2027.

CMS Announces an Optional Hold Harmless Period for Medicaid Work Requirements

What's happening: The Centers for Medicare & Medicaid Services (CMS) announced via a State Medicaid Director Letter that it is offering all states an optional "hold harmless period" through June 30, 2027, during which states that choose this option may suspend eligibility denials and disenrollments when applicable individuals do not demonstrate compliance with community engagement requirements (commonly referred to as work requirements).

Why it matters: The hold harmless period defers enforcement in states that elect it; it does not change the Jan. 1, 2027 implementation date.

- In states that elect the option, individuals who are otherwise eligible would not be denied coverage or disenrolled solely for failing to demonstrate compliance during the state's approved hold harmless period, which may extend through June 30, 2027.
- **The hold harmless period may reduce early coverage disruptions and could shift enforcement-related enrollment changes later into 2027.**
- Because the hold harmless period is voluntary for states, Plans operating in multiple states may see differing approaches and timelines.

The details: The guidance addresses the following:

- **Optional, state-elected transition period.** All states may elect a hold harmless period through June 30, 2027.

- **State election and CMS approval.** States must request the hold harmless period through their CMS-approved mitigation plans. States intending to use the option beginning Jan. 1, 2027, are asked to notify CMS by Dec. 11, 2026.
- **Assessments continue; adverse actions pause.** States that use the hold harmless period will continue to assess whether individuals meet the community engagement requirement or are excluded from it. However, they will not deny applications or disenroll otherwise eligible individuals solely for failing to meet the requirement. The hold harmless period does not apply to denials or disenrollments based on eligibility criteria other than the community engagement requirement.
- **Implementation date unchanged.** States must still implement the community engagement requirement no later than Jan. 1, 2027.
- **Purpose of the transition period.** CMS intends the period to let states modernize systems, refine processes and learn from the early months of implementation, including workforce training needs and the beneficiary experience. CMS acknowledges that states are still addressing implementation issues, such as updating eligibility determination logic and system-generated notices and maintaining timely eligibility processing.
- **CMS expectations for all implementing states.** Whether or not they elect the hold harmless period, CMS strongly encourages states to:

    - **Maximize automated verification** using reliable data already available to the state before asking individuals for more information to verify qualifying activities or identify exclusions.
    - **Make the process clear and easy to navigate** with timely notices that explain what the state has already verified, what is still needed and how to respond or get help.
    - **Test and strengthen end-to-end processes** by confirming that data matching, notices, and eligibility decisions work together to minimize inappropriate coverage disruptions and beneficiary burden.

Temporary Moratorium on New Agent/Broker Registration to Participate in the Exchanges No Longer In Effect

A federal judge blocked a CMS interim final rule that paused new registrations for agents and brokers without 2026 agreements to help consumers enroll through the individual marketplace.

Why this matters: The ruling clears the way for new agents and brokers to begin training and help consumers enroll during open enrollment, which runs through mid-January — restoring access to enrollment assistance as concerns about marketplace enrollment and affordability grow.

The details: The pause, which CMS put in place to address improper enrollments and fraud, kept nearly 19,000 agents and brokers from registering on the federal marketplace and in states that use the federal platform.

- Two broker trade groups, the National Association of Benefits and Insurance Professionals and Health Agents for America , sued, arguing CMS bypassed public comment and failed to consider the financial harm to brokers.

BCBSA supported the court's decision keeps critical enrollment support available to consumers through the end of open enrollment.

- Before the ruling, BCBSA urged CMS to take a more targeted, risk-based approach to fraud that focuses on high-risk actors, protects access to trusted enrollment help — including insurer-contracted agents — and provides more transparency and notice before any future pauses.

Yes, and: Beyond the broker pause, other CMS and Treasury/IRS proposals could affect marketplace enrollment and affordability by changing eligibility verification, withholding financial assistance from some consumers with unresolved data matches and ending automatic renewals beginning in 2028.

Departments Announce New IDR Entity Available for Disputes

The Departments of Health and Human Services, Labor and the Treasury (Departments) announced a recently certified independent dispute resolution (IDR) entity (IDRE), Physio Solutions, LLC, is now available to adjudicate disputes submitted to the Federal IDR process. The Departments previously announced the certification of Physio Solutions as an IDRE.

The Departments maintain a current list of available IDREs. There are multiple IDREs under review for recertification following the closing of public petition periods, and the Departments will make future announcements regarding those applications.

CMS Awards $10 Billion to States in Second Year of Rural Health Transformation Program

The Centers for Medicare & Medicaid Services (CMS) announced it awarded $10 billion to all 50 states for the second year of the $50 billion Rural Health Transformation Program (RHTP).

Why this matters: The fiscal year 2027 funding will support state initiatives to expand rural healthcare access, strengthen the healthcare workforce, improve chronic disease management, and invest in technology and innovative care delivery models.

Award amounts were determined in part by states' progress implementing their approved transformation plans, with CMS reviewing annual reports submitted by all 50 states and considering implementation of certain state health policies. CMS will continue monitoring state implementation and providing technical assistance to support the development of sustainable rural healthcare systems.

CMS Extends and Modifies Nationwide Freeze on New Medicare Hospice and Home Health Enrollment for Six Months

CMS recently issued guidance to extend its nationwide moratoria on new Medicare enrollments for hospices and home health agencies (HHAs) for an additional six months to address fraud, waste, and abuse.

Why this matters: The moratoria extensions will allow currently enrolled hospices and HHAs to add new practice locations in their existing enrollment, and the extensions will not affect existing Medicare enrollments or prevent currently enrolled providers from delivering services. Regarding Medicaid and CHIP, CMS indicates states have the discretion to decide whether a hospice and/or HHA moratorium is appropriate for their respective Medicaid and CHIP programs and states have the discretion to determine the scope of any such moratorium.

Healthcare Advisory Committee Advances Recommendations on Behavioral Health, Medicare Advantage, and Administrative Simplification

The Healthcare Advisory Committee to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) met November 9 to review and approve recommendations from six workgroups focused on behavioral health integration, care for vulnerable populations, Medicare Advantage (MA), program integrity, administrative burden reduction, and health data modernization.

A major focus of the meeting was expanding the Collaborative Care Model (CoCM) to improve behavioral health integration. Recommendations included transitioning from time-based reimbursement to condition- or episode-based payments, requiring Medicaid coverage and reimbursement of CoCM services at Medicare-equivalent rates, eliminating prior authorization and other administrative requirements, standardizing workforce requirements, and reducing patient cost-sharing. The committee also discussed broader payment reforms and potential expansion of the model to additional conditions.

The Improving Care for Vulnerable Populations Workgroup advanced recommendations to expand coverage of medically tailored meals for high-risk Medicare, Medicaid, and dual-eligible beneficiaries; strengthen pediatric nutrition insecurity screening through Medicaid's EPSDT benefit; improve coordination with federal nutrition assistance programs; and modernize psychiatric hospital regulations. Members emphasized the importance of demonstrating return on investment and long-term financial sustainability.

Recommendations from the Crushing Fraud, Waste, and Abuse Workgroup focused on strengthening pre-payment claim integrity tools, improving consistency across Medicare Administrative Contractor local coverage determinations (LCDs), and reducing payment disparities for clinically comparable services where differences cannot be justified by patient complexity, quality, access, or infrastructure requirements.

The Strengthening Medicare Advantage Workgroup recommended addressing overlapping Medicare Advantage and Veterans Affairs (VA) payments through enhanced data sharing and reconciliation, reforming agent and broker compensation by establishing fiduciary responsibilities to beneficiaries, and improving transparency around provider networks, drug coverage, out-of-pocket costs, and access to services.

Additional recommendations included adopting a national semantic data model and harmonized quality reporting framework across federal healthcare programs to reduce administrative burden, as well as streamlining provider credentialing and modernizing Medicaid data systems through real-time, API-based

data exchange. The committee also discussed future work on outcomes-based quality measurement, including efforts to shift quality reporting away from process measures and toward patient outcomes in areas such as pressure injuries, advance care planning, and chronic kidney disease progression.

Why this matters: While these recommendations are advisory and do not have the force of law, they provide insight into policy areas CMS and HHS leadership may prioritize in future rulemaking, demonstrations, guidance, and payment reform efforts. Several recommendations could have significant implications for health plans, providers, and employer-sponsored coverage.

State Issues

Pennsylvania

Legislative

Legislative Update

The House last week returned to session for their last scheduled session days of the 2025-2026 legislative session. These days were organizational and ceremonial in nature, with departing members having the opportunity to provide farewell remarks on the floor of the House, and with the caucuses electing their leaders for the 2027-2028 legislative session.

The House Democratic caucus made no changes in their leadership team, with the Republican caucus replacing Representative Struzzi with Representative Barton as the Appropriations Chair and Representative Delozier with Representative Marla Brown as the Caucus Administrator. The remainder of the Committee Chairs will be formally announced when they return to session on January 5.

The Senate returns to session this week for their organizational and ceremonial days. Ahead of session the Senate Democrats announced their leadership as they move into the majority. Senator Costa has been nominated as President Pro Tempore, which will require the entire Senate to vote on when they come into session. Senator Maria Collett will become the first Democratic female Senate Majority Leader in Pennsylvania history. Senator Hughes will remain chair of the Appropriations Committee. Steve Santarsiero will be Majority Whip, Lisa Boscola will be the Majority Caucus Chair, Sharif Street will be the Majority Caucus Secretary, Marty Flynn will become the Majority Caucus Administrator and Nick Miller the Majority Policy Chair.

The Senate Republicans will vote on their new leadership this week.

After this week there are no further session days scheduled for the year, with session ending Sine Die on the 30th. Both chambers will return to session on the Constitutionally required day of January 5.

Industry Trends

Policy / Market Trends

AHIP Spotlights *No Surprises Act* Arbitration ‘Run Amok’

AHIP published a new blog showing how provider-driven abuse of the *No Surprises Act's* IDR system is driving up Americans' health care costs.

New Developments:

- In a new piece from *The Conversation*, published in *The Washington Post*, Lindsey Murtagh, a former CMS official who helped write the rules implementing the *No Surprises Act,* warned that relentless provider-driven abuse of the law's arbitration (IDR) process is driving up healthcare costs for employers and consumers.
- On November 2, the chair and ranking member of the House Energy and Commerce Committee sent a bipartisan letter to the CBO stating the "IDR process is **not functioning as Congress intended**" and "appears to be contributing to **significant costs** to the health care system, and resulting in **higher premiums for consumers and employers**."

Key Takeaways:

- "[A] small number of out-of-network providers are **using the law to extract enormous payments** from health plans. This behavior is **starting to drive up the cost of coverage for both employers and individuals**. In my view, if left unaddressed, these increases **will only get steeper**."
- "What's driving up costs is an arbitration process run amok ... **Providers are winning the vast majority – roughly 85% of these disputes**. They are also using arbitration more than expected. The federal government estimated there would be 17,000 disputes annually. Last year, there were **more than 2 million disputes, many brought by providers with private equity investment**. And the volume of disputes has grown every year." "Absent action by Congress, I fear that the protection the No Surprises Act offers Americans will **come at a cost that ultimately limits consumers' access to health insurance**."

What AHIP Is Saying: "Common-sense, bipartisan policy solutions are needed to stop this gold rush by some out-of-network providers and private equity firms who relentlessly flood the arbitration system with ineligible claims and extract outrageous overpayments to maximize their profits by driving Americans' healthcare costs higher." – Chris Bond, AHIP spokesman.

Dive Deeper: Read the full piece from *The Conversation* in *The Washington Post* here.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
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